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ABSTRACT

This inservice journal is a diary of the inservice programs that were held in 1982-1983 for volunteers and paid staff working in the patient relations department at Highland Park Hospital in Highland Park, Illinois. The first section of the journal contains a list of the purposes of inservice education. Summarized next are individual inservice sessions on the following topics: historical perspectives of patient relations departments, interdepartmental exchanges, three stages in human development, holidays in hospitals, burnout, and effects of unemployment on patients. A summary of the year-long inservice program concludes the journal. Appended to the diary are a list of inservice program participants, patient relations guidelines for inservice programs, and a descriptive announcement of a family network program. (MN)

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A PATIENT REPRESENTATIVE INSERVICE JOURNAL

by

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Director - Patient Relations
and
HER STAFF

August 1, 1983

Highland Park Hospital
Highland Park, Illinois

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ABSTRACT

The Patient Relations Department of Highland Park Hospital serves as a bridge on behalf of the patients between other departments in the hospital and between the patients and community services. The structure of the bridge and the essence of the service depends on the high quality of caring, concerned listening and reporting by the patient representatives.

Through inservice within the Patient Relations Department, volunteers and paid staff prepare themselves to be responsive to the changing needs of the hospital population. During the 1982-83 year, the department maintained a diary of their inservice meetings. Adaptations included:

1. Assistance in securing private duty nursing personnel.
2. Communication with patients following discharge.
3. Arranging for visits to patient by community services.
4. Informing patients about x-ray procedures.
5. Working with Dietary Department regarding special needs.
6. Cooperating in training volunteers for service in the lounges of the Intensive Care Units.
7. Arranging housing for out-of-town relatives of patients.

The diary also reflects the affective side of the patient representative process, for the patient and for the representatives.

INTRODUCTION

The Patient Relations Department of Highland Park Hospital was established mid-year in 1979. The department began with a full-time director, a part-time secretary and, as the department became established, 25 to 30 volunteers. In 1982 a part-time counselor was added. The volunteers are recruited, screened and assigned provisionally to the Director of Patient Relations by the Director of Volunteers. After orientation, if the volunteer and the Director of Patient Relations are mutually agreeable, the volunteer may accept an assignment for one or more half-days each week. A close working relationship exists between the Director of Volunteers and the Director of Patient Relations.

In addition to informal, ongoing inservice, the patient representative attends bimonthly inservice meetings. Staff members from Nursing, Social Work, Home Health, Discharge Planning, Dietary, Housekeeping and other departments, as appropriate, are invited. From time-to-time representatives from community services also share in these meetings. (Example 1). A broad, flexible outline is used as a guide for the inservice meetings (Example 2).

The patient's hospitalization is viewed in relation to his past and future, not as an isolated experience. Therefore, it becomes important to assist in making connections with appropriate departments in the hospital and significant agencies in the community. Physical recovery is perceived as being related to emotional well being.

PURPOSE OF INSERVICE

1. To review the procedures of the department.
2. To increase understanding of the meaning of the hospitalization.
3. To develop services responsive to changing needs.

The volunteers are mature men and women with a variety of experience and expertise in the professions and business world.

The essence of the patient representatives' experience is in their relationships with the patient, hospital staff and one another. They describe the work as rewarding, humbling and heartening. Sometimes the role is frustrating because of the limitations involved. The center of the process is listening, caring.

After a year of working together, the participants shared their rewards and problems. They expressed appreciation for their own blessings and the ability to be helpful; concern when help was not possible.

HISTORICAL PERSPECTIVES

May 14, 1982

At this meeting we refer to the relatively recent development of Patient Relation Departments in hospitals throughout the United States. We refer to the literature, such as "Why Patient Representative Programs"[1] and review some of the reasons why these services have grown. Patients need to be advised of rights they may not be aware of. The department attempts to insure satisfaction through concern for the patient and facilitating relationships between departments that delivery services to the patient. There is increasing evidence of the positive relationship between good mental health and healing.[2] The dichotomy between the mind and the body is being recognized as an artificial separation of an interactive system.[3]

We discuss the expectations of the representatives, hours, behavior, when to handle a problem, when to refer to the Director, how to translate the data on the hospital registration card. We gain insights from how frequently the patient has been hospitalized, whether there is a family support system, the patient's age and the nature of the illness.

We play a serious but amusing game of "What would you do if ——the door is closed?.....the nurse says don't go in?.....there are two people in the bed?.....the patient complains about the food, the housekeeping?....there are questions about the bill, insurance, treatment in special departments?" This first meeting dealt with these and other questions in detail. Exploration of meaning of each situation was encouraged, humor and caring imperative.

INTERDEPARTMENTAL EXCHANGES

July 9, 1982

Radiology personnel asked if selected volunteers would undertake inservice in understanding x-ray procedures in order to help the patient prepare for these experiences. Thus, an additional, helpful service was begun.

Today the Assistant Vice President of Nursing attended our inservice to share insights on the positive relationship that the department has on the attitude of the patient.[4] Pressures on nursing were discussed, such as the impact of the economy, increase in medical technology, increase in need for specialization in nursing care, and staff reductions.

We recalled an earlier meeting with personnel from our community Senior Center when a plea had been made for the provision of "finger foods" for the partially sighted and our older population.

Complex issues in medical treatment recalled Heart Sounds[5]. Confidentiality concerns are discussed regularly. At this meeting we also dealt with individual and cultural differences.[6] We recognized that whether food seems good may depend on what kind of food one normally is accustomed to. The fact that one is about to be discharged from the hospital may be a source of joy or anxiety. Simple dietary or housekeeping requests or problems may be dealt with directly by the patient representative. Where policy or personal complaints are involved, they are referred to the Director of Patient Relations for follow-up.

THREE STAGES IN HUMAN DEVELOPMENT

September 10, 1982

Our guest today was the Director of a family social agency[7] in our community. Three groups with special needs were discussed: the new parent, newly separated couples, and the older adult. Because something of the previous status of each group was lost, each had to relate to a process of mourning, response to loss and readjustment.

Parenthood was described as both a joy and responsibility, implying changes for both parents. Associated fears and anxieties are normal. If there is concern about closeness, or excessive need of either parent, there may be ambivalence about the newborn. A new agency in the community, Family Network (Example 3), serving parents of young children was discussed. It was also discussed with the pediatricians and obstetricians at their monthly meeting.

Another vulnerable group described was the family that had been separated through death or divorce. Mourning, anger and depression were discussed as well as defensive behavior such a overactivity and vulnerability. There are economic and social outcomes of loss.

Aging is another period of loss for many. Approximately thirty percent of the hospital population is over 65. By the year 2000, it is estimated that the older adult population in the United States will increase by 119 percent.[8] "Growing old is not for sissies."[9] Aging does not come in a uniform package. Chronology and physiology may not coincide with the individual's mental or emotional development. Nursing homes were also discussed at this meeting.

HOLIDAYS IN HOSPITALS

November 12, 1983

Two new requests for service have come to the department; help in locating housing for out-of-town relatives of patients, and assistance in securing help for patients when they are discharged. The group shared ideas and suggested options.

The Social Services Supervisor[10] discussed what may happen to people who must be in the hospital at holidays and special occasions. Young people have their sense of invulnerability shaken. Illness may be a new experience and they feel that it is unfair. The adolescent feels loss of fantasies for the future. In middle age the sense of life slipping by is magnified at the holidays. Depression at such times may related to unrealistic expectations that lead to more than the usual sense of disappointment.

The patient's family may have additional burdens and responsibilities because of the hospitalization and the inability of the patient to carry out his usual part of the festivities.

Recommendations included more physical closeness to patients; touching, reassuring. Issues of family concerns need to be heard. Flexibility about celebrating on alternate dates can be encouraged. We need to be aware of anniversary issues, where reactions of previous years are stirred up. We need to help patients differentiate between what is possible for them and what must be accepted.

New equipment and another service developed during this interval. We learned about the telephone adjustment for the hearing impaired patient and what the patient representative could do in this regard.

The Social Services Supervisor[11] shared ideas about factors that trigger stress, now often call burn-out. These factors could be related to social change, economic instability, normal developmental changes, changing cultural expectations and roles, idealization of youth, depreciation of the elderly, and devaluation of spirituality. Many stressful pressures are work-related, such as lack of support, confusion regarding expectations, boredom, increase in technology, and higher adaptation requirements. Stress can be negative or positive; the latter can be motivating.

Suggestions for dealing with stress included separating oneself from it, making decisions about priorities, being realistic about expectations, "organize your worrying". Often things take on a better perspective when they are verbalized. Activity can relieve stress, relaxation techniques may be helpful. Each of us ranked ourselves on a social readjustment scale related to stress.[12]

Maladaptive responses to stress include denial, reversion, rigidity and oversimplification. Burn-out is complex, individual and must be explored to be resolved.

INSIDE OUT

March 11, 1983

It seemed appropriate at the end of our inservice year, to again look at the interdependence of our patients, their families, our hospital and the community. We read the following[13]

> "...physical symptoms, including chest pains, shortness of breath, headaches, dizziness, dry mouth, and eczema... They may suffer a loss of self esteem. Marital problems may appear. The children may present symptoms of stress."

The group conjectured what kind of problem might cause the foregoing symptoms and reactions. The discussion led to the article which actually described the effect of unemployment on a patient, his mind, body and on his relationships. We discussed the narrow line the patient representative must follow to express caring without becoming intrusive.

Careful listening is our primary tool. We may express empathy without assuming total understanding. Generalizing often gives a kind of security. Sharing options may provide hope. We decided that a patient generally does not want advice, or to be told we know how they feel or to be unduly cheerful or distracting.

The Director of Patient Relations determines, in consultation with the volunteer, when a referral to Social Service may be suggested. Senior centers and family service agencies now send personnel to the hospital (upon request) to encourage the patient's later participation.

SUMMARY

As the foregoing twelve-month period was reviewed with the patient representatives, they expressed concern that too successful a portrait might have been painted. They said not every contact was productive; they did not always feel they had been as helpful as they might have liked.

The Department of Patient Relations plays a unique role in the hospital institution. It is easily accessible to all one and all and flexible in its operation. Because of its diversity and continual adaptation, the department may be more difficult to describe than a more circumscribed one.

It really works alone, but in conjunction with other departments.

The boundaries of the work performed in the Patient Relations Department shift in response to the needs. We think it is a good place to be.

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6. Schultz, Sandra L. "How Southeast Asian Refugees in California Adapt to Unfamiliar Health Care Practices". National Association of Social Workers, Health and Social Work, May 1982.

7. Isadora Sherman, Director of North Suburban Jewish Family and Community Services, Resource Guest Speaker.

8. "Information on Aging" Institute of Gerontology, No. 23, October 1981.

9. Joan and Erik Erikson, Life Span Conference, Maryland, 1982.

10. Ronni Weinstein, Social Services Supervisor, Highland Park Hospital, Resource Guest Speaker.

11. Ronni Weinstein, as above.

12. Holmes Scale and Burn-Out Index

13. "Unemployment", Journal of Contemporary Social Work, February 1983.

EXAMPLE I

PARTICIPANTS

Volunteers in Patient Relations

Lois Ascherman
Elaine Baron
Bernard Blatt
Lynn Cole
Andrea Cutler
Joyce Davis
Judy Farby
Bobbe Fried
Marlene Goldberger
Ruth Kahnweiler
Barbara Keno
Barbara Kupferberg
Art Levy
Joyce Levy
Betty Morris
Georganne Morrison
Ellen Somberg
Bert Wallenstein
Dorie Weinberg

Hospital Staff and Community Representatives

Nadine Biddison	Secretary-Patient Relations
Jane Carter	Patient Representative
Janet Freund	Counselor
Shirley Garrison	Director-Patient Relations
Donna Hofmann	Discharge Planning
Maxine Inlander	Director-Volunteers
Gwen Lorimer	Assistant Vice President-Nursing
Arlene Miller	Social Work Volunteer
Donna Ohlwein	Secretary-Social Work
Paula Seifert	Highland Park Senior Center
Isadora Sherman	JFC Service
Pat Taylor	Winnetka Senior Center
Ronni Weinstein	Social Services Supervisor

EXAMPLE 2

PATIENT RELATIONS GUIDELINES for INSERVICE

1. Procedures
   - 1.1 Relationships with Volunteer Department
   - 1.2 Training
     - publications
     - inservice
     - rounds
   - 1.3 Assignment
     - in office preparation
     - on floor visits
     - special situations
   - 1.4 Patient Contact
     - role
     - concerns
     - alternatives
   - 1.5 Routines
     - recording
     - follow through

2. Meanings
   - 2.1 Alliances
     - investments
     - support
   - 2.2 Perspectives
     - problems

3. Outcomes
   - 3.1 For the hospital services and patients
   - 3.2 For staff
     - volunteer and paid
   - 3.3 Interface with community and services
   - 3.4 Expectations and reality

EXAMPLE 3

FAMILY NETWORK

GOALS	To assist parents of young children in providing nurturing which will promote the physical and mental health of children through: . a mutual support group of parents . an open, caring atmosphere in which to meet . providing information about community resources . arranging discussions about child development
WHY NOW	Because child rearing can be stressful as well as joyful Because there are more single parent homes Because there is more cultural diversity and complexity
WHERE	Downstairs in the Presbyterian Church, 330 Laurel, Highland Park, Illinois. There is one room where children are cared for while parents meet in an adjacent room.
WHEN	Tuesday and Friday 9 - 4 Thursday 1 - 4 and 6 - 8 Future hours may be adjusted, as needed
WHO MAY COME	Open to <u>all</u> parents of children through age three for whom the center is geographically accessible. Non-sectarian.
COST	There is no fee for participation. Funds are raised by gifts to defray expenses. Many services are provided by volunteers. Contributions are welcome, materials, volunteers, cash. Not-for-profit status.
PROGRAM	Is developed by mutual agreement of participating parents, staff and board of directors. It may include: . discussion groups, with or without resource speakers . hobbies, sewing, quilting, book reviews . outreach to encourage parents to share in the support from FAMILY NETWORK

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and

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